

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Glenmore Medical PC
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No.	17-24-1337-9749
Applicant's File No.	BT23-265838
Insurer's Claim File No.	0341783800101106
NAIC No.	22063

ARBITRATION AWARD

I, Maryann Mirabelli, the undersigned arbitrator, designated by the American Arbitration Association pursuant to the Rules for New York State No-Fault Arbitration, adopted pursuant to regulations promulgated by the Superintendent of Insurance, having been duly sworn, and having heard the proofs and allegations of the parties make the following **AWARD**:

Injured Person(s) hereinafter referred to as: Assignor

1. Hearing(s) held on 02/04/2025
Declared closed by the arbitrator on 02/04/2025

James DiCarlo, Esq, from The Tadchiev Law Firm, P.C. participated virtually for the Applicant

Christa Varone from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$9,677.73**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant has reduced the claim to \$5982.35 based upon a fee schedule reduction.

Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

The arbitration arises out of a motor vehicle accident which took place on 4/7/21, whereby the Assignor (AS) a then 59-year-old female driver was allegedly injured in the accident and sought treatment with the provider. Applicant is seeking reimbursement in the amount of \$5982.35 for the surgeon's bill (\$5404.11) and the assistant surgeon's bill

(\$578.24) for an arthroscopy performed on 11/7/23, along with interest and counsel fees, under the No-Fault Regulations in connection with injuries sustained in the motor vehicle accident.

The threshold issue presented at the hearing is whether Respondent's lack of medical necessity defense predicated upon an independent medical examination ("IME") can be sustained. Respondent also raised a fee schedule defense.

4. Findings, Conclusions, and Basis Therefor

The hearing proceeded by ZOOM.

This decision is based upon the written submissions of counsel for the respective parties as well as oral argument. I have reviewed the documents contained in the Record as of the date of the hearing.

Upon reviewing the evidence submitted by the Applicant, I find the Applicant submitted sufficient credible evidence to establish a prima facie case with the respect to the services that are the subject of this arbitration. See, Mary Immaculate Hospital v. Allstate Insurance Co., 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004) Once Applicant has made out a prima facie case, the burden shifts to Respondent to timely request additional verification, deny, or pay the claim. Hospital for Joint Diseases v. Travelers Prop. Cas. Ins. Co., 9 NY3d 312 (2007). Respondent has timely denied these claims predicated upon a lack of medical necessity defense based upon an IME conducted by Howard Kiernan, MD, on 10/11/21, which terminated further benefits as of 10/22/21.

The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment, such as by a consultant conducting an IME of the patient. Kingsbrook Jewish Med. Ctr v. Allstate Ins. Co., 61 AD3d 13 (App Div 2d Dept 2009). An IME report must provide a factual basis and medical rationale for the consultant's conclusion that further treatment is not medically necessary. Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance, 20 Misc.3d 144(A) (App Term 2d & 11th Jud Dists. 2008). If an IME report provides a factual basis and medical rationale for a respondent's consultant's opinion that services were not medically necessary and the applicant fails to present any evidence to refute that showing, the claim should be denied, as the ultimate burden of proof on the issue of medical necessity lies with the applicant. AJS Chiropractic, P.C. v. Mercury Ins. Co., 22 Misc.3d 133(A) (App Term 2d & 11th Jud Dists 2002). See, Insurance Law § 5102; Wagner v. Baird, 208 AD2d 1087 (App Div 3d Dept 1994)

Respondent advises that there is a linked award which sustained this defense for the claim for the facility fee associated with this surgery which was performed here. In AAA Award No., 17-24-1332-4258, Arbitrator Callahan upheld this defense predicated upon this IME. In her award she notes based upon her review of the IME,

From the time of the accident to the IME, the EIP had received physical therapy, chiropractic care massage therapy and heat treatment at a frequency of 3 times per week provided temporary relief. She reported to Dr. Kiernan that she received left ankle/foot injections and denied pending surgery or injection. The doctor had a host of records to review in conjunction with his IME. Most germane is his review of the MRI scan of the left knee by Dr. Patel of 5/24/21 it noted a complex tear of the body and posterior horn of medial meniscus with high-grade partial tear and sprains to ACL. Many other MRIs and records were reviewed, including follow-up reports. The IME report is detailed. He performed an orthopedic of bilateral shoulders and elbows, bilateral hands and wrists, bilateral hips bilateral knees, ankles, and feet. Inasmuch as this claim centers on the left knee surgery, the pertinent part of this IME is Dr. Kiernan's examination of the left knee. There was no heat, swelling, effusion, erythema, crepitus noted. There were no complaints of pain on palpation. No less than 11 orthopedic tests were performed, including McMurray, anterior and posterior drawer, Lockman. All orthopedic tests were negative. Range of motion was full in extension and flexion. Strength was normal. The orthopedic exam was entirely normal. The neurological exam was normal.

She found the Respondent sustained its burden. She goes on to note,

"Once respondent meets his burden, "plaintiff must rebut it or succumb." Bedford Park Medical Practice PC v American Transit Ins. Co, 8 Misc.3d 1025(A), 2005 N.Y. Slip Op. 51282(U) (Civ.Ct. Kings Co. Aug. 12, 2005).

Applicant argues against the denial based upon Dr. Kiernan's IME, and presents a rebuttal from the treating surgeon Dr. Ronald Daly. It is undated. Basically Dr. Daly opines that based upon the positive MRI findings (October 5, 2023, which noted a tear in the horn of the medial meniscus), that the surgery was medically necessary.

Respondent argues in support of the denial based upon the IME of Dr. Kiernan, performed 6 months postaccident. She makes cogent arguments that no contemporaneous medical records are provided. This is conceded by the parties. There are no records provided for service of treatment subsequent to Dr. Kiernan's IME October 2021, and the surgery, performed 2 years later, in November 2023.

There must be an adequate explanation for gaps in treatment. Delorbe v. Perez, 59 A.D. 3d 491, 873 NYS 2d 198 (2d Dept. 2009)."

She sustained the defense noting,

"An insurer cannot be deemed to be responsible for medical care for an indefinite period of time after an accident absent serial reports documenting treatment without significant breaks in therapy. This situation is analogous to that which is contemplated by 11 NYCRR§ 65 - 3.16 (a) (3), which states that in accordance with Insurance Law §5102(a) (1), an insurer shall not be liable for

payment of medical and other benefits if, during a period of one year from the date of the accident, no such expenses have been incurred. In this case, the absence of proof of interim treatment attenuates the medical necessity for the services and supports respondent's defense." Applicant v. Geico Insurance Company, AAA#412012130558 (Arbitrator Weisman, 1/5/14)"

She concluded,

"Respondent has substantiated their denial of claim based upon the IME. I am not persuaded by applicant's arguments that a surgery (and therefore a facility fee) performed two years after said IME is shown to be necessary. Further, respondent argues that the rebuttal ought be given little weight as it is not based upon a medical record review other than the rebuttal doctor's own operative report 2 years after. (Supervising acupuncturist affidavit fails to raise a triable issue since it was not based on an examination of patient nor did it address or rebut the findings of objective medical tests detailed in a swarm report of defendants medical expert. Insureds subjective complaint of pain cannot overcome objective medical test .See Rummel G.Mendoza, DC, PC v. Chubb Indem. Ins. Co., 47 Misc 3d 156, 2015 NY Slip Op. 50900 (U) (App. Term, 1st Dept 2015). This claim is therefore denied. Issues regarding fee schedule are rendered moot."

There has been no new evidence submitted to rebut the IME or which would persuade me to find differently than my esteemed colleague. Therefore, I find for the Respondent and need not address the fee schedule issue raised.

Pursuant to 11 NYCRR 65-4 (Regulation 68-D), §65-4.5, an Arbitrator shall be the judge of the relevance and materiality of the evidence offered...The Arbitrator may question any witness or party and independently raise any issue that the Arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department Regulations. Master Arbitrator Peter J. Merani, in the case of Sports Medicine & Orthopedic Rehabilitation a/a/o "I.B." v. Country-Wide Insurance Co., AAA Case No. 17-R-991-14272-3, stated, in relevant part, that *"the Arbitrator below is the trier of facts and must evaluate and weigh the evidence presented at the hearing in arrive at [his/her] decision. The Arbitrator, in weighing the evidence, has broad powers and discretion in determining what evidence is relevant and material. The Arbitrator is in the best position to evaluate the evidence and decide on the credibility of the submitted documents"*.

This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator.

5. Optional imposition of administrative costs on Applicant.
Applicable for arbitration requests filed on and after March 1, 2002.

I do NOT impose the administrative costs of arbitration to the applicant, in the amount established for the current calendar year by the Designated Organization.

6. I find as follows with regard to the policy issues before me:

- ☐ The policy was not in force on the date of the accident
- ☐ The applicant was excluded under policy conditions or exclusions
- ☐ The applicant violated policy conditions, resulting in exclusion from coverage
- ☐ The applicant was not an "eligible injured person"
- ☐ The conditions for MVAIC eligibility were not met
- ☐ The injured person was not a "qualified person" (under the MVAIC)
- ☐ The applicant's injuries didn't arise out of the "use or operation" of a motor vehicle
- ☐ The respondent is not subject to the jurisdiction of the New York No-Fault arbitration forum

Accordingly, the claim is DENIED in its entirety

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of NY

SS :

County of Nassau

I, Maryann Mirabelli, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

02/05/2025

(Dated)

Maryann Mirabelli

IMPORTANT NOTICE

This award is payable within 30 calendar days of the date of transmittal of award to parties.

This award is final and binding unless modified or vacated by a master arbitrator. Insurance Department Regulation No. 68 (11 NYCRR 65-4.10) contains time limits and grounds upon which this award may be appealed to a master arbitrator. An appeal to a master arbitrator must be made within 21 days after the mailing of this award. All insurers have copies of the regulation. Applicants may obtain a copy from the Insurance Department.

ELECTRONIC SIGNATURE

Document Name: Final Award Form
Unique Modria Document ID:
8bdb21f60ab1dbc0062cc0bf73f279f8

Electronically Signed

Your name: Maryann Mirabelli
Signed on: 02/05/2025